31st does not apply; or

(iii) the cost report shall end on the last date of service if a provider change occurs before 11 months of operation and the interim rate was based on a projected cost report.

(C) The historical cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(D) A subsequent overlapping 12-month historical cost report shall be filed for the calendar year ending December 31st, if the first cost report does not end on that date.

(b) Projected cost data.

(1) Projected cost reports for providers.

(A) If a provider is required to submit a projected cost report under subsection (c), (d) or (g) of K.A.R. 30-10-18, the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report shall begin on the first day of the month closest to the date that the provider, who meets the criteria for filing a projected cost report, is certified by the department of health and environment.

(C) The projected cost report shall end of the last day of the 12-month period following the date specified in paragraph (B), except:

(i) The projected cost report shall end on December 31st when that date is not more than one month before or after the end of the 12-month period; or

(ii) the projected cost report shall end on the provider's normal fiscal year-end used

for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria for filing the projected cost report ending on December 31st does not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in-state or out-of-state, shall allocate central office costs to each facility being paid rates from the projected cost data at the end of the provider's fiscal or calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities on projection status shall be consistent with the method used to allocate such costs to those facilities in the chain who are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit amended cost reports revising cost report information previously submitted when the error or omission is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the report.

(d) Due dates of cost reports.

(1) Calendar year cost reports shall be received not later than the close of business on the last working day of February following the year covered by the report.

(2) Historical cost reports covering the projection status period shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Cost reports approved for a filing extension in accordance with K.A.R. 30-10-17(e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado or other accidents that are not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The request shall be in writing and shall be received by the agency before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the medicaid/medikan director when the cause for further delay is beyond the control of the provider. The request shall be received by the agency before the due date of the cost report or it shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties.

(1) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be withheld and suspended until the complete nursing facility financial and statistical report has been received.

(2) Failure to submit cost information within one year after the end of the cost report period shall be cause for termination from the medicaid/medikan program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions s as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall submit a working trial balance with the cost report. The working trial balance shall contain account numbers,

descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. The working trial balance shall reconcile to the cost report schedules.

(i) An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(j) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995.)

ATTACHMENT TO 30-10-17

State of Kansas
Department of Social and Rehabilitation Services
Adult and Medical Services

MS-2004
REV 12/95

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

SEND TO:	AGENCY USE ONLY		
KANSAS DEPT OF SOCIAL & REHABILITATION SERVICES NURSING FACILITY REIMBURSEMENT ADULT AND MEDICAL SERVICES COMMISSION, 6TH FLOOR, RM 628S DOCKING STATE OFFICE BUILDING 915 S.W. HARRISON TOPEKA, KANSAS 66612-1570	(1,2)		
	(3,4)		
	(5,6)		

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

PROVIDER ID NUMBER	11. EMPLOYER'S FEDERAL ID NUMBER
4	
12. PROVIDER NAME (THE PERSON OR BUSINESS ORGANIZATION RESPONSIBLE FOR MEETING REQUIREMENTS, PROVIDING SERVICES AND RECEIVING PAYMENTS.)	13. FACILITY NAME
14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP)	

16. ADMINISTRATOR'S NAME	17. PHONE NUMBER	18. REPORT PERIOD	19. FISCAL YEAR END
	( )	/ / TO / /	/ /

CHECK ONLY ONE
21.____EXISTING FACILITY (HISTORICAL) 22.____NEW PROVIDER (PROJECTED)
23.____NEW FACILITY (PROJECTED) 24.____HISTORICAL R/Y SAME AS PROJECTED PERIOD
25.____HISTORICAL F/Y OVERLAPS PROJECTION PERIOD

CHECK ONLY ONE
26.____SOLE PROPRIETORSHIP 27.____PARTNERSHIP 28.____CORPORATION-PROFIT
29.____CORPORATION-NON PROFIT 30.____CITY OWNED 31.____COUNTY OWNED
32.____OTHER (SPECIFY)

FACILITY BEDS	(1) BEG OF PERIOD	(2) INCREASE (DECR)	(3) DATE OF CHANGE	(4) END OF PERIOD
41. NURSING FACILITY (NF)				
42. NF-MENTAL HEALTH				
44. OTHER				
45. TOTAL LICENSED BEDS				

46. TOTAL BED DAYS		
48. TOTAL RESIDENT DAYS (ALL RESIDENTS FROM AU-3902) (4)		
48a. TOTAL MEDICAID DAYS (5)		
48b. TOTAL MEDICARE DAYS		

51. IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS? ☐ YES ☐ NO

53. IS THIS FACILITY (please check one): ☐ HOSPITAL BASED LTC ☐ FREE-STANDING NF

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

ADMINISTRATION COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
SALARY - ADMINISTRATOR	101						
SALARY - CO ADMINISTRATOR	102						
OTHER ADMINISTRATIVE SALARIES	103						
EMPLOYEE BENEFITS	104						
OFFICE SUPPLIES & PRINTING	105						
MANAGEMENT CONSULTANT FEES	106						
OWNER/RELATED PARTY COMPENSATION – SCHEDULE C	107						
ALLOCATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS)	108						
PHONE & OTHER COMMUNICATION	109						
TRAVEL	110						
ADVERTISING	111						
LICENSES & DUES	112						
LEGAL, ACCOUNTING, & DP	113						
INSURANCE (EXCEPT LIFE)	114						
INTEREST (EXCEPT RE LOANS)	115						
LEGAL	116						
OTHER (PLEASE SPECIFY)	117						
OTHER (PLEASE SPECIFY)	118						
TOTAL ADMINISTRATION COST CENTER	120						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

PLANT OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
REAL & PERSONAL PROPERTY TAX	121						
SALARIES	126						
EMPLOYEE BENEFITS	127						
OWNER/RELEATED PARTY COMPENSATION SCHEDULE C	128						
UTILITIES (EXCEPT PHONE)	129						
MAINTENANCE & REPAIRS	130						
SUPPLIES	131						
SMALL EQUIPMENT (SEE INSTRUCTIONS)	137						
OTHER (PLEASE SPECIFY)	138						
TOTAL PLANT OPERATING COST CENTER	139						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

ROOM & BOARD COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
EMPLOYEE BENEFITS	141						
DIETARY:							
SALARIES	142						
OWNER/RELATED PARTY COMPENSATION– SCHEDULE C	143						
DIETARY CONSULTANT	144						
FOOD	145						
SUPPLIES	146						
OTHER (PLEASE SPECIFY)	148						
LAUNDRY & LINEN:							
SALARIES	149						
LINEN & BEDDING MATERIAL	150						
SUPPLIES	151						
OTHER (PLEASE SPECIFY)	153						
HOUSEKEEPING:							
SALARIES	154						
SUPPLIES	155						
OTHER (PLEASE SPECIFY)	158						
TOTAL ROOM & BOARD COST CENTER	159						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
NURSING:							
REGISTERED NURSE (RN)	161						
LICENSED PRACTICAL NURSE	162a						
LICENSED MENTAL HEALTH TECH	162b						
NURSE AIDES	163a						
MEDICATION AIDES	163b						
RESTORATIVE/REHAB AIDES	163c						
EMPLOYEE BENEFITS	164						
OWNER/RELATED PARTY COMP–SCHEDULE C	165						
NURSING CONSULTANTS	166						
PURCHASED SERVICES	167						
NURSING SUPPLIES	168						
OTHER (PLEASE SPECIFY)	170						
OTHER PATIENT SERV:							
PHY. THERAPIST SALARY	171a						
OCC. THERAPIST SALARY	171b						
SPEECH THERAPIST SALARY	171c						
RESPIRATORY THRP SALARY	171d						
PSYCH. THERAPIST SALARY	171e						
REC. THERAPIST SALARY	171f						
OWNER/RELATED PARTY COMP–SCHEDULE C	172						
RESIDENT ACTIVITIES SALARY	173a						
SOCIAL WORKER SALARY	173b						
MEDICAL RECORDS SALARIES	173c						
OTHER HC SALARIES (SPECIFY)	173d						
RES ACT SUPPLIES	174						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.						PROVIDER NUMBER	
SCHEDULE A			EXPENSE STATEMENT				
HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
OTHER PATIENT SERV:(CONT)							
OCCU. THERAPY-CONSULT	175						
MEDICAL RECORDS-CONSULT	176						
PHARMACIST-CONSULTANT	177						
SPEECH THERAPY-CONSULT	178						
PHYSICAL THER-CONSULT	179						
CONSULTANT	180						
NURSE AIDE TRAINING	181a						
OTHER HEALTH CARE TRAIN.	181b						
RESIDENT TRANSPORT	182						
OTHER (PLEASE SPECIFY)	183						
OTHER (PLEASE SPECIFY)	188						
TOTAL-HEALTHCARE COST CENTER	189						
TOTAL-RATE FORMULA COSTS	190						
OWNERSHIP COST CENTER							
INTEREST-REAL ESTATE	191						
RENT/LEASE EXPENSE	192						
AMORTIZED LEASEHOLD IMPROVEMENT	193						
DEPRECIATION EXPENSE	194						
TOTAL OWNERSHIP COST CENTER	195						

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER

SCHEDULE A — EXPENSE STATEMENT

NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) SRS ADJUSTMENTS (5)	(AGENCY USE) ADJ RES REL EXPENSES (6)
BAD DEBTS	200				0		
PROVISION FOR INCOME TAXES	201				0		
NON WORKING OWNERS/OFFICERS-SCH C	202				0		
DONATIONS	203				0		
FUND RAISING/PROMO & NON REIMB. ADVERTISING	204				0		
LIFE INSURANCE – OWNERS/OFFICERS	205				0		
OXYGEN PURCHASES & SUPPLIES	206				0		
DRUGS-PHARMACEUTICALS	207				0		
VENDING MACHINES	208				0		
BOARD OF DIRECTORS EXP	209				0		
RESIDENT PURCHASES	210				0		
BARBER/BEAUTY SHOP	211				0		
OTHER (PLEASE SPECIFY)	212				0		
OTHER (PLEASE SPECIFY)	213				0		
TOTAL NON-REIMBURSABLE	214				0		
TOTAL	215						

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

MS-2004

PROVIDER NUMBER

SCHEDULE B EXPENSE RECONCILIATION

	LN#	(1) BOOKS	(2) FED TAX RETURN	(3) COST REPORT
TOTAL EXPENSES PER BOOKS	231			
TOTAL EXPENSES PER FEDERAL TAX RETURN	232			
TOTAL EXPENSES PER COST REPORT (LINE 215, COLUMN 2)	233			
EXPENSES ON BOOKS OR FEDERAL TAX RET NOT ON COST REPORT				
SPECIFY	234			
SPECIFY	235			
EXPENSES ON COST REPORT NOT ON BOOKS OR FEDERAL TAX RETURN				
SPECIFY	237			
SPECIFY	238			
TOTAL (SHOULD BE EQUAL)	240			

SCHEDULE C STATEMENT OF OWNERS AND RELATED PARTIES

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES. IF ANY OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES. ALSO SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES. FOR DEFINITIONS SEE KAR 30-10-1a AND 30-10-24.

NAME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION	
					AMOUNT	LINE #
TOTALS (SHOULD BE EQUAL)						

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF 107, 128, 143, 165, 172, & 202.

MS-2004

SCHEDULE D	STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES AND MORTGAGES PAYABLE					PROVIDER NUMBER
LN#						
301	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	6) INTEREST EXPENSE
302	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 19 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
303	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
304	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	
						(6) INTEREST EXPENSE
305	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
306	LENDER'S NAME & ADDRESS:					
	ITEMS FINANCED:					Reported On: Line 115 ☐ Line 191 ☐
	(1) ORIGINAL DATE AND DURATION	(2) INTEREST RATE	(3) ORIGINAL LOAN AMOUNT	(4) UNPAID BALANCE	(5) TOTAL ANNUAL PAYMENTS	(6) INTEREST EXPENSE
311	TOTALS: Line 115					
	Line 191					

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 115 & 191. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

MS-2004

				PROVIDER NUMBER	
SCHEDULE E - BALANCE SHEET					
BALANCE SHEET SHALL REFLECT THE ASSET, LIABILITY AND RESIDUAL ACCOUNTS OF THIS FACILITY ONLY					
		BEGINNING OF PERIOD		END OF PERIOD	
ASSETS	LN#	(1)	(2)	(3)	(4)
CASH	351				
ACCOUNTS RECEIVABLE	352				
LESS: ALLOWANCE FOR DOUBTFUL ACCT	353	( )		( )	
INVENTORIES & SUPPLIES	354				
*ALL LOANS TO OFFICERS, OWNERS, AND RELATED PARTIES	355				
*ALL ASSETS NOT REL-PATIENT CARE	356				
*ASSETS HELD FOR INVESTMENT	357				
NURSING HOME PLANT & EQUIPMENT:					
BUILDING	358				
LESS: ACCUMULATED DEPRECIATION	359	( )		( )	
EQUIPMENT	360				
LESS: ACCUMULATED DEPRECIATION	361	( )		( )	
LEASEHOLD IMPROVEMENTS	362				
LESS: ACCUMULATED DEPRECIATION	363	( )		( )	
LAND	364				
OTHER	365				
OTHER	366				
TOTAL ASSETS	369				
LIABILITIES & OWNER'S EQUITY					
ACCOUNTS PAYABLE	371				
OTHER CURRENT LIABILITIES	372				
*ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	373				
MORTGAGE PAYABLE	374				
OTHER LONG TERM LIABILITIES	375				
OWNER' S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS – SEE INSTRUCTIONS)					
	377				
	378				
	379				
TOTAL LIAB & OWNER'S EQUITY	380				
*IF AMOUNTS EXCEED $10,000 ATTACH SCHEDULE SHOWING DETAILS					

MS-2004

			PROVIDER NUMBER
SCHEDULE F	BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION		
BALANCE AT BEGINNING OF PERIOD-LINE 377, 378 & 379, COLUMN 2	401		
INCREASES:			
REVENUE PER LINE 449, COLUMN 1	402		
INVESTMENT BY OWNER	403		
TRANSFERS FROM CENTRAL OFFICE	404		
COMMON STOCK SOLD	405		
OTHER (SPECIFY)	406		
OTHER (SPECIFY)	407		
TOTAL INCREASES	408		
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 215, COLUMN 2	411		
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	412		
TRANSFERS TO CENTRAL OFFICE	413		
DIVIDENDS PAID TO STOCKHOLDERS	414		
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	415		
OTHER (SPECIFY)	416		
OTHER (SPECIFY)	417		
TOTAL DECREASES	418		( )
BALANCE AT END OF PERIOD-LINE 377, 378 & 379, COLUMN 4	419		

MS-2004

PROVIDER NUMBER

SCHEDULE G REVENUE STATEMENT

	LN#	(1) REV PER BOOKS OR FED TAX RETURN	(2) ADJUSTMENT TO EXPENSE ACCOUNTS	(3) LINE NUMBER OF RELATED EXPENSE
ROUTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	431			
MEDICAID RESIDENTS & PATIENT LIABILITY	432			
MEDICARE RESIDENTS	433			
VETERAN ADMINISTRATION RESIDENTS	434			
OTHER RESIDENTS (SPECIFY)	435			
PHARMACY - DRUGS & MEDICATIONS	436			
ROUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENT	437			
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	438			
BEAUTY/BARBER SHOP	439			
RESIDENT PURCHASES/NON ROUTINE ITEMS SOLD	440			
PURCHASE DISCOUNTS, RETURNS & ALLOWANCES	441			
OTHER SUPPLIES SOLD	442			
PROGRAM REIMBURSEMENTS & TAX CREDITS	443			
INVESTMENT/INTEREST INCOME	444			
VENDING MACHINE REVENUE	445			
DAY CARE/TREATMENT INCOME	446			
OTHER (SPECIFY)	447			
OTHER (SPECIFY)	448			
TOTALS	449			

MS-2004

	PROVIDER NUMBER

SCHEDULE H — STATEMENT OF RELATED ADULT CARE HOME INFORMATION

461 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATIONS? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE I.
IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
465			
466			
467			
468			
469			
470			
471			
472			
473			
474			
475			
476			
477			
478			
479			
480			

MS-2004

		PROVIDER NUMBER	
	SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE		
481	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?	☐ YES	☐ NO
482	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?	☐ YES	☐ NO
	IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 493.		

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
485			
486			
487			
488			
489			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES.

491	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED	☐ YES	☐ NO
492	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
493	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
494	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION? (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
495	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO
496	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT? IF NO, SUMBIT COPIES OF DOCUMENT NOW	☐ YES	☐ NO

MS-2004

PROVIDER NUMBER

SCHEDULE J EMPLOYEE TURNOVER REPORT

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	PART-TIME
497	ADMINISTRATOR						
498	CO-ADMINISTRATOR						
499	OTHER ADMINISTRATIVE						
500	PLANT OPERATING						
501	DIETARY						
502	LAUNDRY						
503	HOUSEKEEPING						
504	REGISTERED NURSES						
505	LPN						
506	LICENSED M/H TECH						
507	AIDES						
508	PHYSICAL THERAPIST						
509	SPEECH THERAPIST						
510	OCCUPATIONAL THERAPIST						
511	RESPIRATORY THERAPIST						
512	PSYCH THERAPIST						
513	RECREATION THERAPIST						
514	RESIDENT ACTIVITY						
515	SOCIAL WORKER						
516	MEDICAL RECORDS						
517	OTHER HEALTH CARE						
518	TOTAL ALL CLASSIFICATION						

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAS THE REPORT BEEN SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORTS SCHEDULES COMPLETE?
3. ARE TWO (2) COPIES OF THE COMPLETED COST REPORT AND ONE COPY OF THE AU-3902 (CENSUS SHEET) BEING SUBMITTED?
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?

(a) TRIAL BALANCE USED TO PREPARE THE COST REPORT ☐
(b) DEPRECIATION SCHEDULE ☐
(c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES ☐
(d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE) ☐
(e) CURRENT MANAGMENT CONSULTANT AGREEMENT ☐
(f) CENSUS SHEETS (AU-3902) ☐
(g) LEVEL OF CARE CHARGE SCHEDULES ☐
(h) SCHEDULE OF LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES (FOR LOANS IN EXCESS OF $10,000) ☐

DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR _____(PROVIDER NAME AND NUMBER) FOR THE COST REPORT PERIOD BEGINNING_____, 19_____, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	( )

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER	

TITLE/POSITION	DATE

NAME (PRINT OR TYPE)